

PRINTED: 03/10/2011  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN1934	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/09/2011
NAME OF PROVIDER OR SUPPLIER  MCKENDREE VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4347 LEBANON ROAD HERMITAGE, TN 37076		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  During the annual Licensure and Complaint TN0002766 survey conducted on March 7 through March 9, 2011, at Mckendree Village, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

FRED R. LEVOY  
Administrator

TITLE

(X6) DATE

March 23, 2011

STATE FORM

0099

0NV711

If continuation sheet 1 of 1